

**DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES**

*Quality Assurance Division-Licensure Bureau*

*2401 Colonial Drive*

*P.O. Box 202953*

*Helena, MT 59620-2953*

*FAX: (406) 444-1742*

**ASSISTED LIVING FACILITY LICENSE APPLICATION**

**Indicate number of Beds requesting to be licensed in each category:**

**CATEGORY A:**              **CATEGORY B:**(5 or less)              **CATEGORY C:**              (may equal Category A #)

*(Include completed Category B and C applications if applying for these licenses.)*

Facility Name:

Facility Address:      PO Box:

City:      State/Zip:      County:

Facility Telephone Number:      FAX:

Facility E-mail/Web page Address :

**Floor Plan is:**      ☐ **New Construction**      ☐ **Existing Structure**      ☐ **Addition**      ☐ **Remodeled**

Name of Applicant:

Applicant Address:      City:      State/Zip:

Applicant (or contact) e-mail address:

\*Administrator of Facility:

Owner (If different from Applicant):

Owner Address:      City:      State/Zip:

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- \* **37.106.2814 ADMINISTRATOR (2)** (a) the administrator must hold a current Montana nursing home administrator license; or  
(b) have proof of holding a current and valid nursing home administrator license from another state; or  
(c) have successfully completed all of the self study modules of "The Management Library for Administrators and Executive Directors", a component of the assisted living training system published by the assisted living federation of America university (ALFA); or  
(i) be enrolled in the self study course referenced above, with a six month successful completion;

Revised November 25, 2004

**Information on ownership, contract, or lease agreement if operated by a person other than the owner:**

- ☐ A partnership, firm or association. List every member thereof.
- ☐ A corporation. List the name and address thereof and the names of its officers.

*Name:*      *Address:*

*Name:*      *Address:*

*Name:*      *Address:*

*Name:*      *Address:*

*Name:*      *Address:*

*Name:*      *Address:*

*Name:*      *Address:*

*Name:*      *Address:*

*Name:*      *Address:*

*Name:*      *Address:*

*Name:*      *Address:*

*Name:*      *Address:*

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(Please attach additional sheets as needed.)

Check the following if they are correct:

☐ The applicant or any person managing have never been convicted of a felony. Section 50-5-207 (c)

**50-5-207 MCA. Denial, suspension, or revocation of health care facility license -- provisional license.** (c) The applicant or any person managing it has been convicted of a felony and denial of a license on that basis is consistent with **37-1-203** or the applicant otherwise shows evidence of character traits inimical to the health and safety of patients or residents.

☐ The applicant and managing personnel have never been denied a license. (Section 50-5-207 (c) including stipulations of Section 37-1-203).

**37-1-203 MCA.** Conviction not a sole basis for denial. Criminal convictions shall not operate as an automatic bar to being licensed to enter any occupation in the state of Montana. No licensing authority shall refuse to license a person solely on the basis of a previous criminal conviction; provided, however, where a license applicant has been convicted of a criminal offense and such criminal offense relates to the public health, welfare, and safety as it applies to the occupation for which the license is sought, the licensing agency may, after investigation, find that the applicant so convicted has not been sufficiently rehabilitated as to warrant the public trust and deny the issuance of a license.

☐ The applicant has the financial ability to operate the facility in accordance with law or rules or standards adopted by the Licensure Department (Section 50-5-207 (d)).

*Application for license for an Assisted Living Facility is hereby submitted under the provision of Section 50-5-101 through 50-5-228. (See attached)*

**SIGNED:**

**DATE:**

**TITLE:**

**ADDRESS:      CITY:      STATE/ZIP:**

Enclose a check, money order or draft made payable to the *Department of Public Health & Human Services* to cover the license fee. The fee is determined as follows:

(a) facilities with 20 or less = \$20.00

(b) facilities with 21 beds or more = \$1.00 per bed.

This fee will be deposited in the State Treasury and is non-refundable.

*For additional information see the following Web Pages:*

<http://www.dphhs.state.mt.us/>

*Click on:*    **Health Care Facility Licensure Information**